(47)

Supreme Court, U.S.
FILED
OCT 16 1989
JOSEPH F. SPANIOL, JR.
CLERK

No. 88-1503.

In the

Supreme Court of the United States.

OCTOBER TERM, 1989.

NANCY BETH CRUZAN,
BY HER PARENTS AND CO-GUARDIANS,
LESTER L. AND JOYCE CRUZAN,
PETITIONERS,
v.
DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
RESPONDENTS,
v.
THAD C. McCANSE, GUARDIAN AD LITEM,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE MISSOURI SUPREME COURT.

Brief of *Amici Curiae* in Support of Respondents, Catholic Lawyers Guild of the Archdiocese of Boston, Inc., St. Thomas More Catholic Lawyers Association, Archdiocese of New Orleans, Guild of Catholic Lawyers of the Archdiocese of New York.

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Interest of These Catholic Lawyers Guilds.

The members of the above lawyers guilds ascribe, *inter alia,* to promote the science of ethics, particularly the systematic application of ethical principles to concrete legal issues and

to seek to protect the legal and moral rights of all people. Owing to these ideals, the members feel compelled to address certain issues necessarily underlying this appeal, specifically: (1) the unalienable character of life, and (2) the supremacy of the state's interest in life and the prevention of suicide over substituted, qualified liberty interests, constitutional or otherwise. As practitioners who, in part, define their identities as well as derive their livelihood from the system of American jurisprudence, the members of these guilds submit that they have a direct and substantial interest in this Court's resolution of the conflicting values presented by this appeal.[1]

Summary of the Argument.

The state's interest in life and the prevention of suicide supersedes the right to withhold or withdraw nutrition and hydration in all instances. Human life is unalienable, but individual rights to privacy and autonomy are limited and qualified. Historically, the state has undertaken to protect individuals from harming themselves in numerous areas of the law, and the state should appropriately be allowed to act to preserve life in this context.

Nutrition and hydration are profoundly distinct from medical treatment and can never be morally withheld or withdrawn from a person, regardless of the preferences of the patient or the patient's guardian. Nutrition and hydration constitute a basic necessity of life and a matter of routine care, not a medical treatment aimed at a pathological condition. The withholding or withdrawal of nutrition and hydration, which themselves are never self-generating, is biologically final in a way, and with a degree of certainty, that the withdrawal of medical treatment is not. To withhold or withdraw nutrition and hydration is to cause death by starvation, a means independent of the patient's underlying pathological condition. To permit the withholding or withdrawal of nourishment constitutes tacit acceptance of the value judgment that the individual's life is not worth living and is tantamount to the sanctioning of suicide or euthanasia.

Nutrition and hydration may, in all cases, be provided in a simple, noninvasive manner and should never be regarded as unduly burdensome. The provision of food and water has special cultural significance and is symbolic of societal care, support and compassion. The withholding or withdrawal of nutrition and hydration would undermine patients' trust and confidence in physicians and violate expectations regarding minimum standards of care. The withholding or withdrawal of nutrition and hydration, in this and all cases, would also cause a painful and agonizing death. Depriving non-terminal patients such as Nancy Cruzan of food and water would create dangerous precedent and could readily lead to the active euthanasia of others besides her including defective newborns, the severely handicapped or retarded, and the elderly.

This Court should establish as a guiding principle that nutrition and hydration may never be withheld or withdrawn from any individual under any circumstances. This approach would provide a clear dividing line for health care practitioners and would reaffirm the overriding value of human life in American jurisprudence.

[1] The written consents of counsel of record have been filed with the clerk of this Court.

Argument.

I. The Inviability of Human Life Supersedes and Predominates the Right to Withhold or Withdraw Nutrition and Hydration in All Instances.

A. *The Right to Life Is Unalienable and Unqualified.*

Human life is an unalienable right and is the necessary source and condition of every human activity and of all society. See 1 Blackstone, *Commentaries* 129-130; *Declaration of Independence*, par. 2. "Sanctity of life is not just a vague theological precept. It is the foundation of a free society." Cantor, "A Patient's Decision to Decline Life-Saving Treatment: Bodily Integrity Versus the Preservation of Life," 26 Rutgers L. Rev. 228 (1973). Life is a gift and privilege of the most fundamental and profound value, which each individual has a duty to preserve and make prosperous. See Connery, "The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration," 2 Issues in L. and Med. 87, 87-88 (1986). Since life is a gift over which persons have stewardship, but not absolute dominion, one must never directly intend to cause the death of an innocent person whether oneself or another. This is a command of Natural Law that generally does not allow for exception. McCartney, "Catholic Positions on Withholding Sustenance for the Terminally Ill," *Health Progress* at 39 (October 1986).

B. *The Individual's Rights to Privacy and Autonomy Are Limited and Necessarily Qualified.*

The individual's rights to privacy and autonomy in American law are necessarily limited "by clear and unquestionable authority of law." *Union Pac. Ry. Co.* v. *Botsford,* 141 U.S. 250, 251 (1891). Even the premier advocate of individual rights, John Stuart Mill, recognized that personal autonomy represents a qualified right which may be regulated by the state. See Mill, *Utilitarianism* and *On Liberty* at 235-236 (M.

Warnock Fontana Library ed. 1962) (state may prevent individual from voluntarily alienating his or her rights).

Historically, the state may regulate, and has regulated, an individual's course of conduct in order to prevent the individual from harming himself or herself. There are numerous areas of American law where the state has undertaken to protect individuals against their own imprudence. See *Buck* v. *Bell,* 274 U.S. 200 (1927) (sterilization); *Zucht* v. *King,* 260 U.S. 174 (1922) (vaccination); *Jacobson* v. *Massachusetts,* 197 U.S. 11 (1905) (vaccination). The "state may regulate its internal affairs for the protection and promotion of general health, safety, morals and welfare of its citizens even where it proves inconvenient or offensive to a particular individual." Note, "Compulsory Medical Treatment: The State's Interest Re-evaluated," 51 Minn. L. Rev. 293, 297 (1966). See *National Treasury Employees Union* v. *Von Raab,* ____ U.S. ____, 109 S.Ct. 1384 (1989) (drug testing); *Schmerber* v. *California,* 384 U.S. 757 (1966) (blood samples). See also *People* v. *Carmichael,* 56 Misc. 388, 288 N.Y.S.2d 931 (Genesse County Ct. 1968) (motorcyclist protective helmets); *DeAryan* v. *Butler,* 119 Cal.App.2d 674, 260 P.2d 98 (1953), cert. denied, 347 U.S. 1012 (1954) (flouridation of water); *State* v. *Massey,* 229 N.C. 734, 51 S.E.2d 179 (1949), appeal dismissed, 336 U.S. 942 (1949) (snake handling as expression of religious belief); *Davis* v. *State,* 118 Ohio St. 25, 160 N.E. 473 (1928) (palm reading and fortune telling). A plethora of pure food and drug laws, licensure schemes, and regulations controlling noxious substances exists which interfere with individual freedom of choice and prevents consumers from injuring themselves.[2] These laws prevent individuals from subject-

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[2] ... the context of medical treatment, a physician's professional judgment, as a general matter, may be legally restricted or precluded in many situations. Laws governing narcotics, experimental drugs, and compulsory reporting demonstrate that professional judgment is not always a paramount consideraton. See

ing themselves to risks which the government considers inadvisable and effectively preclude persons from individual self-determination and from selecting their own risks. See *United States* v. *Walsh,* 331 U.S. 432 (1947); *Purity Extract & Tonic Co.* v. *Lynch,* 226 U.S. 192 (1912).

In light of this history and precedent, the constitutional right of privacy must be regarded as qualified. This Court has previously identified only "marriage, procreation, contraception, family relationships, child rearing and education" as implicating privacy rights. Note, "The Refusal of Lifesaving Medical Treatment v. The State's Interest in the Preservation of Life," 58 Wash. U.L.Q. 85, 98 n.62 (1980). In *Bowers* v. *Hardwick,* 478 U.S. 186, 194 (1986), this Court cautioned against expanding the right of privacy. The derivative or substituted right to die or to refuse lifesaving measures alleged in the case at bar does not fall within any of the above categories and should not be included among the penumbra of interests protected by the right of privacy.

C. *An Individual Does Not Have the Right to Terminate His or Her Life by Refusing Nourishment.*

A number of courts have ruled that individuals, whether terminal or non-terminal, competent or incompetent, do not have either the autonomy or the right to stop their nutrition and hydration. In *Von Holden* v. *Chapman,* 87 App. Div. 2d 66, 66-67, 450 N.Y.S.2d 623, 624-625 (4th Dept. 1982), a case involving a hunger-striking prisoner, a New York appellate court held that the state's interests in preserving life were paramount to the rights asserted by an inmate who was attempting to starve himself to death and thus authorized the state psy-

Rosenberg, *Compulsory Disclosure Statutes*, 280 N. Eng. J. Med. 1287 (1969). See generally Baron, "Medical Paternalism and the Rule of Law," 4 Amer. J. of L. and Med. 337, 340 ("A decision to end the life of a terminally ill patient is no more a mere 'medical question' to be decided by doctors than a decision to declare war is a mere 'military question' to be decided by generals.").

chiatric center, where the prisoner was temporarily in custody, to force-feed him.

In *State ex rel. White* v. *Narick,* 292 S.E.2d 54 (W. Va. 1982), another prisoner sought injunctive relief to prevent officials from force-feeding him. The *Narick* court held that the state's interests in the preservation of human life and the prevention of suicide easily outweighed the right to self-determination, and thus dismissed the privacy claim. *Id.* at 58.

In the case of *In re Conroy,* 190 N.J. Super. 453, 464 A.2d 303, 306-307 (App. Div. 1983), the New Jersey court refused to permit the guardian of an incompetent patient to remove a nasogastric tube on the patient's behalf. In *Conroy,* the court found that nutrition was a basic necessity of life and therefore the administration of food and water through the nasogastric tube was not medical treatment that could be refused or withdrawn. The court in *Conroy* concluded that even if the patient would have chosen to terminate medical treatment had she been able to, she could not have properly refused food and, therefore, her guardian could not have refused it for her.

In the case of *In re Barry,* 445 So.2d 365 (Fla. Dist. Ct. App. 1984), the Florida court authorized the removal of a ventilator life-support system from an infant who was in a chronic vegetative coma. The court ordered the attending physicians not to furnish life-sustaining procedures except for the purposes of alleviating the child's pain and suffering and of providing him comfort and "normal nutrition." The court considered nutrition to be a normal part of the care required for the child while waiting for him to die.

In this case, the Court should similarly rule that the court-appointed guardians here may not cause the death of Nancy Cruzan by denying her nutrition and hydration. In so ruling, the Court should establish as a guiding principle that food and water must be distinguished from medical treatment in all instances where the withdrawal of medical care is being con-

sidered. This Court should emphatically state that the provision of nutrition and hydration is never excessively burdensome and that intravenous, nasogastric, or stomach tube feeding should, once implemented, be continued in all cases in which it can sustain life.

II. Nutrition and Hydration Are Profoundly Distinct from Medical Treatment and May Never Be Morally Withdrawn from a Person.

Legal scholars and ethicians have postulated a variety of reasons why food should be distinguished from medical treatment in the determination of what types of medical care morally can be withdrawn from persons. Many of these reasons are briefly summarized *infra*.

A. *Nutrition and Hydration Constitute a Basic Necessity of Life and of Routine Care, Not Medical Treatment.*

Nutrition and hydration are not medical treatment because they differ in effect on the body. Nutrition and hydration are extrinsic natural resources of the body that are used by the body in all instances to sustain its natural functions and to support its natural defenses against diseases. Barry, *Facing Hard Cases: The Ethics of Assisted Feeding*, 2 Issues in L. & Med. 99, 100-101 (1986); Meilaender, *On Removing Food and Water: Against the Stream*, 14 Hastings Center Rep. 11, 12 (1984) (nourishment is not a cure in itself, but care that humans owe one another to sustain life). Nutrition and hydration do not directly, proximately, or immediately cure any clinically diagnosable pathological condition, but rather meet the essential need of the body for basic resources.

In contrast, medical treatments directly, proximately, and immediately cure, remedy, and palliate clinically diagnosable conditions and, unlike nutrition and hydration, are only indirectly and remotely natural extrinsic resources of the body. Nutrition and hydration might temporarily alleviate pain and indirectly have some neurological impact, but only indirectly because their provision meets a need of the body for basic and extrinsic resources. See Barry, 2 Issues in L. & Med., *supra* at 100-101. See also *In re Conroy*, 464 A.2d at 312 ("Nourishment itself does not cure disease. Neither is it an artificial life-sustaining device. Rather, it is a basic necessity of life whose withdrawal causes death and whose provision permits life to continue until the patient dies of his illness or injury.").

The fact that nutrition and hydration may be administered by an intravenous or stomach tube does not transform them into medical treatments:

> "[T]he mode of provision of nutrition and fluids does not make them a medical treatment. If that were not the case, then one would be logically committed to the view that the provision of poisons by a hypodermic injection would be a medical treatment, while providing it orally would be homicide. Assisted feeding is different from the use of respirators for a number of reasons. Respirators assist the inhaling and exhaling functions of the body. On the other hand, assisted feeding by IV, NG or stomach tube does not assist the swallowing function . . . ."

Barry, *supra* at 101-102.

The distinction between the withholding or withdrawal of nutrition and hydration and the withholding or withdrawal of medical treatment is particularly compelling in a case like the

present one where the patient cannot personally feed herself. These circumstances represent a challenge to our decency and concern as a human community. Nancy Cruzan, like other patients with persistent neurological deficits, is not in this respect unique: a similar challenge is presented by some quadraplegic veterans, by most small children, and by all human infants. All depend for their lives upon the freely-given assistance of others. The food provided to Ms. Cruzan, to other handicapped patients, or to children is not transmuted into elective medical treatment by the mere fact that assistance is required to provide it.

In this regard, the suggestion by certain *amici* in this case, that feeding the persistently unconscious is useless, is erroneously value-laden and objectionable. The view that nutrition and hydration must have a positive impact on a person's neurological functioning should not have any bearing on decisions to provide them. To require that providing food and water have a positive neurological impact presumes a quality of life judgment that discriminates on the basis of neurological capacity. See May, et al., "Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons," 3 Issues in L. & Med. 203, 209 (1987).

> "The primary aim in providing food and water is to sustain natural organic operations and defenses, and hydration and feeding is of use and of benefit when they can do this. Improving neurological functioning is only a secondary aim in providing these, and food and water should not be considered useless if they can sustain life, but do not improve neurological functioning."

Barry, 2 Issues in L. & Med., *supra* at 105. Feeding patients such as Ms. Cruzan and providing them with fluids is not useless in even the most restrictive sense because it brings these patients a great benefit, namely, the preservation of their lives and the prevention of their death through malnutrition and dehydration.

B. *Nutrition and Hydration Are Never Self-Generating and Their Withdrawal, Unlike that of Medical Treatment, Actively and Inevitably Causes Death.*

The withholding or withdrawal of nutrition and hydration is biologically "final" in a way, and with a degree of certainty, that the withholding or withdrawal of medical treatment is not. The withholding of medical treatment does not guarantee that the patient will die: Karen Quinlan confounded expert medical opinion by surviving the withdrawal of artificial respiratory support and Jehovah's Witnesses sometimes confound medical opinion by surviving the withholding of medically necessary blood transfusions. But it is never possible for a patient to survive the withholding or withdrawal of food and fluids: the withholding or withdrawal of nutrition and hydration *guarantees* the death of the patient.

> "[M]uch of the time when we cease to provide nourishment for the permanently unconscious but biologically tenacious patient, we will not be stopping treatment aimed at disease. We will simply be withholding the nourishment that sustains all human beings whether healthy or ill, and the only result of our action can be death. At what, other than that death, could we be aiming? We might think that the same could be said of turning off a respirator, and it is certainly true that air to breathe is as essential

> to life as food for eating. Yet, there are also important differences. Remove a person from a respirator and he may die — but, then, he may also continue to breathe spontaneously. Hence, the common practice of trying to wean a person from the respirator is a sensible one; we can understand its point, and that point is not that we aim to kill. If the patient breathes successfully without assistance, it is not our task — unless we were really aiming at his death — now to smother him (or stop feeding him). But deprive a person of nourishment and he will die as surely as if we had administered a lethal drug, and it is harder to claim that we did not aim at his death."

Meilaender, "The Confused, the Voiceless, the Perverse: Shall We Give Them Food and Drink?" 2 Issues in L. & Med. 133, 140 (1986). See also Derr, "Why Food and Fluids Can Never Be Denied," 16 Hastings Center Rep. 28, 29 (1986) (death is universal consequence of denial of food and fluids); Harber, "Withholding Food and Water from a Patient," 16 Pac. L. J. 877, 891 (1985) ("[W]hen a physician disconnects a feeding tube, the patient will die just as surely as if the doctor had shot the patient. Removing a feeding tube is necessarily incompatible with the patient's survival. Food, unlike respiration, is never self-generating and must always come from a source outside the patient's own body. The disconnection of feeding tubes does not allow for alternative outcomes; the patient's death is assured. Because the disconnection of feeding tubes necessarily results in the termination of the patient's life, the physicians disconnecting the tubes have actively caused the patient to die.").

The withdrawal or withholding of nutrition and hydration thus violates a fundamental distinction drawn by philosophers and legal scholars between actively taking a life and passively

allowing a patient to live or die. See *id.* at 890-891. Actively taking a life entails engaging in conduct that necessarily results in the termination of the life of another: there is no alternative outcome. Conversely, passively allowing a patient to live or die is not an act that necessarily terminates the life of another but allows for two possible alternative outcomes: life or death. Taking a patient off a respirator, for example, may in fact allow that person to die, but this line of conduct also may be compatible with the patient's continued survival as in the *Quinlan* case. Taking a patient such as Nancy Cruzan off nutrition and hydration, however, necessarily results in the termination of her life and thus those responsible for the withdrawal have actively caused the death. See *id.* at 893 ("A distinction may be made between intentionally causing a patient's death and allowing the patient to either live or die. When food is withdrawn, the patient's death is assured. Since food is never self-generated, the withdrawal of food is necessarily incompatible with the patient's continued survival. When medical care such as a respirator is removed, the patient may either live or die. Thus, the alternative outcome of life is allowed and the doctor has not intentionally killed as is the case when food is denied.").

C. *To Withdraw Nutrition and Hydration Is to Cause Death by a Means Independent of the Underlying Illness.*

When a person must succumb to death, the morally acceptable result is to have the person die from the underlying pathological condition, and not from a lack of basic resources of the body. To bring a person to death, who is not at death's doorstep, by withdrawing food and fluids is to cause death directly and is not a case of allowing the person to die from any underlying pathological condition. When one kills another by culpable omission or benign neglect, one establishes a new

and independent lethal cause either by positive means or by omitting what is required for maintenance by normal care. See Barry, 2 Issues in L. & Med., *supra* at 102-103.

As the New Jersey Court correctly recognized in the *Conroy* case, 464 A.2d at 314, the withdrawal of nutrition and hydration would constitute active euthanasia and would be unethical:

> "If the trial judge's order had been enforced, Conroy would not have died as the result of an existing medical condition, but rather she would have died, and painfully so, as the result of a new and independent condition: dehydration and starvation. Thus, she would have been actively killed by independent means rather than allowed to die of existing illness or injury. Instead of easing her passage from life, the result of the judge's order would have been to inflict new suffering."

Id. at 315. See also Horan and Grant, *Legal Aspects of Withdrawing Nourishment*, 5 J. of Legal Med. 595, 631 (1984) ("[T]he basic fact that withdrawal of nourishment introduces a new cause of death — dehydration and starvation — that may not be related to the underlying disease, constitutes adequate empirical grounds for demanding a more cautious legal approach, if not a different rule of law, for cases involving withdrawal of nourishment.").

It is not clear how one could withhold life-sustaining, medically providable food and fluids without intending the patient's death. Legally, the intentional acceleration of an already certain or imminent death is still murder. W. LaFave & A. Scott, *Handbook of Criminal Law* 250 (1st ed. 1972). Thus, a person who cuts the throat of a terminally ill cancer patient, or a physician who injects an air bubble into his vein, is guilty of homicide even if death from cancer would have occurred

shortly. See *People* v. *Ah Fat*, 48 Cal. 61 (1874); *State* v. *Mally*, 139 Mont. 599, 366 P. 2d 868 (1961).

To deny deliberately nutrition and hydration to persons, whether or not they are in a vegetative state, is homicide, for it is the adoption by choice of a proposal to kill them by starvation and dehydration. See May, et al., 3 Issues in L. & Med., *supra* at 207-208. Such killing can never be morally right and ought never be legalized. It should never be acceptable or legally permitted to withhold food and fluids from the permanently unconscious or from others who are seriously debilitated as a means of securing their deaths.

D. *To Uphold a Purported Right of a Patient to Refuse Nutrition and Hydration Is Tantamount to Sanctioning Suicide and Euthanasia.*

Because food and water are inherently different from medical treatment, a health care provider should always be obligated to provide nourishment to patients, regardless of the obligation, or lack thereof, to provide them with medical treatment. Refusal of food and water by either the patient or his or her guardian is suicide and should not be condoned by the courts. See Harber, 16 Pac. L. J., *supra* at 892 ("A patient's constitutional right of privacy does not give a patient the right to starve to death. Since a patient has no right to commit suicide, the patient has no right to ask a hospital to help the patient commit suicide. Neither may a surrogate refuse food on a patient's behalf."). It is never in the patient's best interest to become malnourished and dehydrated or to elect suicide.[3]

[3] Even the decision of a conscious, competent patient to discontinue nutrition and hydration must be considered dubious. "Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of disease, or the violent reaction to certain surgicial procedures may change our capacity for rational and courageous thought." B. Miller, quoted in Kamisar, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation," 42 Minn. L. Rev. 969, 987-988 (1958).

Antipathy toward suicide extends well beyond the theological realm. The English common law attached both criminal and civil penalties to suicide or attempted suicide. See Cantor, 26 Rutgers L. Rev., *supra* at 228. Suicide was viewed as an offense against nature, violating instincts of self-preservation, as well as an offense against God, the society, and the king. "The common revulsion of western culture towards self-imposed death has, then, an ethical or moral base as well as a religious one. Self-destruction is considered to be contrary to man's natural inclinations, a deprivation of a person's productive capacity [and] an evil example to others . . ." *Id.* at 228.

> "Our society forbids assisting suicide or active euthanasia, even if the motive is compassionate. This prohibition serves to sustain the societal value of respect for life and to provide some safeguards against abuse of the authority to take actions that shorten life. It also encourages us to provide decent and humane care to those who suffer, and to those who are dependent, ill, or impaired. Since these people are already vulnerable to being mistreated, undertreated or avoided, eroding the legal prohibition of active euthanasia might well further endanger them."

Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying at 6 (New York: Hastings Center, 1987). See also Dyck, "An Alternative to the Ethic of Euthanasia," reprinted in *Ethics and Medicine* at 533 (Cam-

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If, for example, a person in this state of extremity were a criminal defendant who had declined the assistance of counsel, it is questionable whether the courts would rule that he had "intelligently and understandingly" waive his rights. See *Moore* v. *Michigan*, 355 U.S. 155, 161 (1957).

bridge: MIT Press 1977) ("If in principle a person can take his or her own life whenever he or she no longer finds it meaningful, there is nothing in principle that prevents anyone from taking his or her life, no matter what the circumstances. For if the decision hinges on whether one regards his or her own life as meaningful, anyone can regard his or her own life as meaningless even under circumstances that would appear to be most fortunate and opportune for an abundant life.").

E. *Nutrition and Hydration May Be Provided in a Simple Noninvasive Manner and Should Never Be Considered Burdensome.*

Feeding an incompetent or unconscious patient through an intravenous or gastrostomy tube, which is in place and functional, does not in any way burden the patient. Expert medical testimony in this case has established that such feeding is burdensome neither to Ms. Cruzan nor to her nursing or medical staff. It is not painful, uncomfortable, difficult, complex, dangerous, or unusual. The provision of nutrition and hydration does not reduce the quality of a patient's life — it simply preserves his or her life. See Horan and Grant, 5 J. of Legal Med., *supra* at 601, 611-612 ("[T]he law should not consider feeding by intravenous or nasogastric means to be equivalent to life-prolonging medical regimens such as ventilators . . . . [N]utrition rarely if ever constitutes a burden to the patient approximating that of more sophisticated medical treatments . . . . As compared to ventilator therapy, dialysis or chemotherapy, intravenous and nasogastric feeding are generally less intrusive and burdensome. Feeding by intravenous means is closely aligned with catheterization and other forms of non-heroic, supportive care."). See also *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275 (1981).

The cost of providing food and fluids by tubes is not, in itself, excessive. Such feeding is generally no more costly than other forms of ordinary nursing care (such as cleaning or spoon-feeding a patient) or ordinary maintenance care (such as the maintenance of room temperature through heating or air conditioning). See May, et al., 3 Issues in L. & Med., *supra* at 210.

Judgments about "burdensomeness" in this context are almost always misplaced. Such judgments may be a euphemism for the subjective value judgment that a patient's life is not worth living — that his or her life *per se* is a burden. See Derr, "Nutrition and Hydration as Elective Therapy," 2 Issues in L. & Med. 25, 38 (1986). However, it is dangerous, if not impossible, to locate a point when the rising cost of maintaining life and declining benefit curves intersect and the costs outweigh the value of life. Kass, "Death As An Event: A Commentary on Robert Morison", in *Ethical Issues in Death and Dying* at 78-79 (Weir ed., 1977).

> "[T]o carefully avoid injustice to anyone and to refuse to impose upon noncompetent persons the judgment of others that they would be better off dead also is to respect their dignity: They are viewed as unique persons, not merely as suffering animals . . . . To hasten death by withholding nutrition and hydration is to adopt the technically easiest and most efficient solution, the solution most in line with those aspects of health administration and medical practice which least comport with the dignity of persons. To provide appropriate and excellent care for the dying is to respect fully not only the dignity of those who are terminally ill but also the dignity of all of their brothers and sisters who must someday join them in death, but who are in no hurry to do so by someone mistakenly or maliciously administering 'death with dignity'."

Grisez and Boyle, *Life and Death with Liberty and Justice* at 181-183 (U. of Notre Dame Press, 1979).

F. *The Provision of Nutrition and Hydration Has Special Cultural and Symbolic Significance.*

The withholding or withdrawal of nutrition and hydration is distinguishable from the withholding or withdrawal of medical treatment by its special cultural and symbolic significance. Providing food and water is a central symbol of care and compassion.

> "Feeding is the first response of the community to the needs of newborns and remains a central mode of nurture and comfort. Eating is associated with social interchange and community, and providing food for someone else is a way to create and maintain bonds of sharing and expressing concern. Furthermore, even the relatively low levels of hunger and thirst that most people have experienced are decidely uncomfortable, and the common image of severe malnutrition or dehydration is one of unremitting agony. Thus, people are rightly eager to provide food and water. Such provision is essential to minimally tolerable existence and a powerful symbol of our concern for each other."

Lynn & Childress, "Must Patients Always Be Given Food and Water?" 13 Hastings Center Rep. 17, 20 (1983).

> "The feeding of the hungry, whether because they are poor or because they are physically unable to feed themselves, is the most fundamental of all human relationships. It is the perfect symbol of the

> fact that human life is inescapably social and communal . . . If the duty of parents toward infants provides a perfect example of inescapable moral obligation, the giving of nourishment is its first and most basic manifestation."

Callahan, *On Feeding the Dying*, 13 Hastings Center Rep. 22 (1983).

Thus, nutrition and hydration not only preserve life and provide comfort, they also constitute ultimate symbols of care and compassion. See also Carson, *The Symbolic Significance of Giving to Eat and Drink*, in *By No Extraordinary Means*, 84, 87 (J. Lynn ed. 1986) ("symbolic significance resides in the mutuality of giving to eat and drink and of taking food and water").[4] To withhold or withdraw nutrition and hydration — to "starve" a patient — can never express or convey care.

Ultimately, the decision to provide nutrition and hydration represents not a personal or elective option, but a non-discretionary matter which defines our core societal values. Life-prolonging treatment "must, in the ultimate, be responsive not only

[4]The powerful cultural, communal and symbolic significance placed on providing food and water has secular and religious origins. See Derr, 2 Issues in L. & Med., *supra* at 34 ("We celebrate birthdays and weddings over cake, anniversaries and new years with champagne. Our most powerful image of maternal love is the mother suckling the baby at her breast . . . . These symbolic meanings are not new, and neither are they merely exclusively 'natural', Yahweh demonstrated his power by drowning Pharoah's army in the Red Sea; but he demonstrated his love by feeding his people (most unnaturally!) with manna from the skies, quail from the desert, and water from solid rock. Jesus announced his public ministry by making wine for a wedding meal — the abundance and quality of the wine signifying to Christians the abundance and perfection of his love — and ended it over supper with his apostles. His last command to Peter was 'feed my sheep!' John 21:17. The central liturgical rites in both the Jewish and the Catholic faiths are meals: the Seder meal for Jews, and the Eucharist meal for Catholics. The richest ideas are called 'food' for thought. Our deepest longings are called 'hungers' and 'thirsts'. And blessed are they who hunger and thirst for justice — for there can be no greater desire for justice than to hunger and thirst. 'What father, being asked by his child for bread, hands him a stone?' Matthew 7:9.").

to the concepts of medicine but also to the common moral judgment of the community at large." *In re Conroy*, 464 A.2d at 314, quoting *In re Quinlan*, 70 N.J. 10, 46, 355 A.2d 647, 663-664 (1976). Since at least the time of Aristotle, it has been recognized that

> "[t]he individual who voluntarily harms himself or permits others to harm him commits an injustice not toward himself but toward the community by depriving it of the services that he owes to it."

Aristotle, *Ethic. Nic.*, V, II, 1138_a10f; *cf.* Thomas Aquinas, *Summa Theologica*, II-II, 59, 3, ad 2_m; 64, 5. Persons do not live purely unto themselves.[5]

To withhold or withdraw from those in poor health the most basic care that they need to survive would be to decide that our society no longer values its members insofar as they are persons with intrinsic dignity — that is, with inherent value independent of what they can do and contribute — but only insofar as they are useful, or so long as their lives have sufficient "quality." However, each individual's life is a gift bestowed and protected by the human community and by the ultimate forces that make up the cycle of birth and death. In life there may be suffering, as there is joy, but suffering does not render a life meaningless or worthless. "Suffering people need the support of others; suffering people should not be encouraged to commit suicide by their community, or that community ceases to be a community." Dyck, *supra* at 533.

[5]"No man is an island, intire of its selfe; every man is a piece of the Continent, a part of the maine . . . and man's death dimishes me, because I am involved in mankind."

John Donne
Devotions Upon Emergent Occasions

> "[C]aring for others expresses recognition of their personhood and responds appropriately to it. For example, care for a baby is the form parental love naturally takes; care for a helpless adult — family member, neighbor, or stranger — expresses compassion and humane appreciation of his or her dignity. It also offers the possibility to the caregiver of nurturing such noble qualities as mercy and compassion.

May, et al., 3 Issues in L. & Med., *supra* at 210-211. See also Grisez and Boyle, *supra* at 228 ("The noneconomic contribution of helpless humans to society can be much more significant if it not merely generates psychological satisfactions but provides an occasion for exercising moral qualities of compassion and fairness.").

G. *The Expectation of Certain Minimal Care, Including Nutrition and Hydration, Is Essential for Maintaining the Trust and Confidence Required for an Effective Physician - Patient Relationship.*

The withdrawal or withholding of nutrition and hydration, unlike medical treatment, could undermine patients' trust and confidence in their physicians and violate their expectations regarding medical care, thus jeopardizing the integrity of the medical profession.

Very few patients expect, when they establish a professional relationship with a physician or healthcare facility, that their lives will depend upon the provision of renal dialysis, artificial respiratory support, cardiopulmonary resuscitation, or even modern antibiotics. Though many competent adult patients are aware that such therapy might, at least in certain circumstances, be withdrawn or withheld, such a possibility can have no

immediate or direct bearing upon their presumption that physicians and health-care facilities will aim to preserve life and never to induce death. But every patient who establishes a professional relationship with a physician or health-care facility knows with certainty that her or his life does depend upon the availability and provision of food and fluids. A public policy that legitimizes the denial of nutrition and hydration would therefore have an immediate and adverse bearing upon the patient-physician relationship. See Derr, 16 Hastings Center Rep., *supra* at 29.

To provide nutrition and hydration in all instances is to understand the basic purpose behind medical care. The objective of medical care is not just to ward off death. That battle will always be lost eventually, and to think of medicine's task in such a way would be to consign it to futility. Medicine's objective, rather, is not so much cure as care — restoration of health when possible, continued care when that is not possible. See Siegler and Weisbard, 145 Arch. Intern. Med. 129, 130 (1985) ("[D]iscontinuation of hydration would sever the therapeutic relationship irrevocably, while maintaining hydration would reinforce the traditional goals of the physician-patient relationship: To cure sometimes, to relieve occasionally, to comfort always . . . . The dedication of the profession to the welfare of patients might be severely undermined in the eyes of the public even by the apparent complicity of physicians in the deaths of the very ill, the permanently unconscious, or the pleasantly senile. The primary commitment of physicians to patients might be compromised and the image of physicians tarnished at precisely the time when physicians must re-establish the primacy of quality of care and not become overwhelmed by cost-containment efforts that run counter to good clinical medicine."); Ayd, 12 *Medical Counterpoint* 20, 22 (June 1970) ("If it were to become an acknowledged function of the medical profession to end life prematurely, could patients place them-

selves with complete trust in the care of a physician? A patient's trust in his doctor is important both for his peace of mind and for his recovery."). The withdrawal or withholding of nutrition and hydration would in effect, constitute an abandonment of the patient by the physician.[6]

See Dyck, *supra* at 534 ("To decide directly to cause the death of a patient is to abandon a cardinal principle of medical practice — namely, to do no harm to one's patient. The relief of suffering, which is surely a time-honored role for the physician, does not extend to an act that presupposes that the life of a patient who is suffering is not worthy to be lived . . . . [N]ot even the patient who is dying can justifiably and unilaterally universalize the principle by which a dying life would be declared to be worthless.").

H. *To Withdraw Nutrition and Hydration Is to Cause a Painful, Agonizing Death.*

The trial court in this case found that Ms. Cruzan is responsive to sound and painful stimuli and exhibits grimacing. *Cruzan, by Cruzan* v. *Harmon*, 760 S.W.2d 408, 411 (Mo. 1988). Ms. Cruzan is "diagnosed as in a persistent vegetative state. . . . She is not terminally ill." *Id.* at 411. Patients such as Ms. Cruzan, who are

[6] The prohibition against abandonment, with roots both in tort and contract, recognizes that once the physician-patient relationship has been established, the physician, in the absence of a special agreement, is under an obligation to attend the case as long as it requires attention. Abandonment "consists of a failure by the physician to continue to provide service to the patient when it is still needed in a case for which the physician has assumed responsibility and from which he has not been properly relieved." D. Louisell & H. Williams, *Medical Malpractice* 217, 219 (1960). See *McGulpin* v. *Bessmer*, 241 Iowa 1119, 43 N.W.2d 121 (1950); *Fortner* v. *Koch*, 272 Mich. 273, 261 N.W. 762 (1935); *Cazzell* v. *Schofield*, 319 Mo. 1169, 8 S.W.2d 580 (1928); *Burnett* v. *Laymen*, 133 Tenn. 323, 181 S.W. 157 (1915); *Vann* v. *Harden*, 187 Va. 555, 47 S.E.2d 314 (1948).

> "in a persistent vegetative state[,] are awake but unaware. Thus, it is inaccurate to describe them as being in a comatose state . . . . Their eyes are open and they may have visual tracking movements. They go through sleep/awake cycles . . . . There may be facial grimacing and yawning . . . . [I]t is more medically accurate to say that a patient in a persistent vegetative state resembles a patient who is demented rather than one who is comatose".

Cranford, "Brain Death and the Persistent Vegetative State," in *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients* at 64 (Doudera and Peters, eds. 1982).

Accordingly, to withdraw or withhold nutrition and hydration from a patient such as Ms. Cruzan is not merciful, but rather will cause her considerable pain and agony.

> "Hunger is the clear awareness of the desire to eat food when the body has been deprived of nutrients beyond a maintenace level, and is often accompanied by abdominal sensations of discomfort ('hunger pains'), irritability and food searching activity. It is a grouping of unpleasant sensations and is generally disagreeable."

Sleisenger and Fordtran, *Gastrointestinal Disease* at 21-22 (2d ed. 1978).

The basic nutritional requirements of every human are protein, carbohydrates, fat, vitamins and minerals. When nutrition is withheld from a person, his or her body is forced to use other sources of energy. Ultimately, the body must rely on protein in its own tissues for energy. "The semi-starved patient . . . will exhibit a marked loss of subcutaneous fat and muscle

wasting, resulting in an emaciated shrunken appearance. It is easily seen that severe malnutrition can affect almost every part of the body." Jones, Dunbar & Jirovec, *Medical Surgical Nursing: A Conceptual Approach* 558-567 (1978).

The physical signs and symptoms of malnutrition include:

1) sparse dull hair;
2) pigmentation on face, scaling or flakiness around nose or mouth;
3) enlarged glands;
4) pale or red eyes; fissures at eyelid corners; dryness of cornea, ring of blood vessels around cornea;
5) redness and swelling of lips;
6) swollen tongue with sores, scarlet and raw;
7) gray or black spots on teeth;
8) spongy gums that bleed easily, receding and pale;
9) muscle wasting, hemorrhages into muscles;
10) spoon-shaped brittle ridged nails;
11) dry, red skin; and
12) enlarged heart, elevated blood pressure.

Id. at 558-567. See also *Harrison's Principles of Internal Medicine* (Isselbacher et al. eds., 9th ed. 1980). In addition, the physical signs and symptoms of dehydration include:

1) a decrease in blood volume;
2) shrunken, wrinkled skin, with pallor or grayish discoloration;
3) decreased salivary flow causing mucous membranes and tongue to become dry; dry tongue with longitudinal furrows;

4) decreased filling of veins;
5) cool moist skin with little elasticity;
6) sunken eyeballs.

Jones, Dunbar, Jirovec, *supra* at 438-440.

I. *The Withdrawal of Nutrition and Hydration from a Non-Terminal Patient Would Create Dangerous Precedent.*

Allowing a patient, guardian, or physician to determine that a non-terminal patient's life is, in effect, "worthless" necessarily involves a subjective judgment of the patient's quality of life and creates dangerous precedent. The same judgment could be applied with equal force to circumstances much different than those present here. See *In re Conroy*, 464 A.2d at 315. "Slight encroachments create new boundaries from which legions of power can seek new territory to capture." *Reid* v. *Covert*, 354 U.S. 1, 39-40 (1957). See Siegler and Weisbard, 145 Arch. Intern. Med., *supra*, at 130 (expressing "deep concerns about accepting the practice of withholding fluids from patients, because it may bear the seeds of unacceptable social consequences. We have witnessed too much history to disregard how easily a society may disvalue the lives of the 'unproductive.' The 'angel of mercy' can become the fanatic, bringing the 'comfort' of death to some who do not clearly want it, then to others who 'would really be better off dead,' and finally, to classes of 'undesirable persons,' which might include the terminally ill, the permanently unconscious, the severely senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps, the aged.").

> "If it becomes entrenched practice to kill by omission certain sorts of persons whose condition is very poor

and whose lives are judged by others no longer to be worth living, then this method of killing surely will be extended to many other persons. Most of the cases that have attracted attention thus far have involved the very severely brain damaged — those who are permanently unconscious, severely damaged by strokes, in advanced stages of dementia due to Alzheimer's or another disease, and so on. But the various sorts of damages, defect, debility, and handicap that burden human lives occur in myriad degrees, so that there are always more and less severe cases differing from one another only by degree. Unfortunately, it is not difficult to imagine a future America in which human life may itself be judged excessively burdensome for all persons who cannot care for themselves and have no one willing and able to care for them."

May, et al., 3 Issues in L. & Med., *supra* at 207.

Dr. Leo Alexander commented on the perverse spread of the euthanasia movement in Nazi Germany in a landmark article in 1949.[7] L. Alexander, *Medical Science Under Dictatorship*, 241 N. Eng. J. Med. 39, 44 (1949). Euthanasia is now openly debated in our society, see Angell, *Euthanasia*,

[7] "Whatever proportions these crimes finally assumed . . . the beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement that there is such a thing as life not worthy to be lived . . . . [From] the severely and chronically sick . . . the sphere of those to be included in this category was enlarged to encompass the . . . unproductive, the . . . unwanted . . . and finally all non-Germans. But . . . the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the [physicians'] attitude toward the nonrehabilitable sick."

319 N.Eng. J. of Med. 1348, 1350 (1988), and scholars are deeply troubled that the practice of withdrawing nutrition and hydration from non-terminal patients could readily lead to active euthanasia of defective newborns,[8] the mentally retarded,[9] and the elderly.[10]

[8] Nontreatment of defective newborns has occurred throughout history, but only recently has the medical profession openly acknowledged the scope and alleged desirability of the practice. In 1973, Doctors Raymond S. Duff and A.G.M. Campbell documented 43 cases of withholding care from defective infants at the Yale-New Haven Hospital, thereby breaking what they characterized as "public and professional silence on a major social taboo." Duff & Campbell, *Moral and Ethical Dilemmas in the Special Nursery*, 289 N. Eng. J. Med. 890, 894 (1973).

[9] See Hollander, *Euthanasia and Mental Retardation: Supporting the Unthinkable*, 27 Mental Retardation 53, 53, 60 (April 1989) ("[T]he prospect of state-sanctioned killing of people with mental retardation [i]s not an idea limited to Nazi Germany . . . . It is all too clear that the idea, and the reality, of killing people with mental retardation is still in the wind in the latter decades of this century . . . .").

[10] "Cost-containment strategies may impose significant financial penalties on those who provide prolonged care for the impaired elderly. In the current environment, it may well prove convenient — and all too easy — to move from recognition of an individual's 'right to die' . . . to a climate enforcing a 'duty to die.'" Siegler and Weisbard, 145 Arch. Intern. Med., *supra* at 131. "The need of transplant surgeons to obtain organs in good condition from cadavers has stimulated the search for tests that would permit the death of the organism as a whole to be declared before the constituent organs have suffered extensive deterioration." Capron and Kass, "A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal" in *Ethical Issues in Death and Dying* 103, 104 (Weir, ed. 1977).

Conclusion.

This Court should affirm the judgment of the Missouri Supreme Court. This Court should also establish as a guiding principle that nutrition and hydration may never be withheld or withdrawn from any individual under any circumstances. If this approach is not adopted, the consequence may be that killing disadvantaged patients will become more accepted and commonplace. Approval of the taking of a patient's life could set a dangerous precedent. Once removal of feeding tubes is condoned, further steps in deciding who should live and who should die is an easier step to take. If a court deems that a patient should not live, and doctors are allowed to take actively the lives of their patients, it is difficult to know at what point this precedent will end. If, however, courts refuse to allow feeding tubes to be removed from patients such as Ms. Cruzan, a bright line of certainty will be established. Doctors will know what type of medical care may be withdrawn from what type of patient. Without such a line, doctors will find themselves in a quandary as to when the removal of feeding tubes is permitted.

Respectfully submitted,

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October 16, 1989

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